STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX **File No. 85079-001-SF**
Petitioner
V

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 24th day of March 2008
By Ken Ross
Commissioner
ORDER

I
PROCEDURAL BACKGROUND

On January 23, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under Public Act No. 495 of 2006, MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it on January 30, 2007.

As required by section 2(2) of Act 495, the Commissioner conducts this external review as though it were an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on February 8, 2008.

The issue in this external review can be decided by a contractual analysis. The Petitioner is enrolled for health coverage with BCBSM through her employment with the State of Michigan, a self-funded group. The provisions of her coverage are governed by the terms of the State of Michigan PPO Your Benefit Guide (benefit guide). The Commissioner reviews contractual issues

pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner has received care from XXXXX, DDS, to treat the internal derangement of her temporomandibular joint (TMJ). Her treatment plan includes office visits and the design of a custom made intraoral orthotic to position and stabilize the mandible. The treatment started on July 24, 2007. The total cost of the treatment plan was $4,700.00.

After initially denying coverage for XXXXX's treatment, BCBSM paid for the Petitioner's care through November 11, 2007. The Petitioner is dissatisfied with the amount BCBSM paid for this care and with BCBSM's failure to pay for any future office visits provided by XXXXX to treat her TMJ problem.

The Petitioner appealed BCBSM's determination. BCBSM held a managerial-level conference on October 30, 2007, and issued a final adverse determination dated November 29, 2007.

III
ISSUE

Is BCBSM required to pay any additional amount for care provided by XXXXX?

IV
ANALYSIS

Petitioner's Argument

In its November 29, 2007, final adverse determination, BCBSM partially reversed its previous position and agreed to make a one-time exception for payments of some of the claims in question. BCBSM cited this language in the benefit guide (pages 36-37):

> Benefits for TMJ or jaw joint-joint disorder are limited to:
>
> - Surgery directly to the jaw joint
> - X-rays (including MRI's)
> - Trigger Point injections

- Arthrocentesis (injections procedures)

Some symptom management services, such as office visits, reversible appliance therapy and physical medicine (diathermy, hot and cold applications) and medications are also covered.

The Petitioner argues that if reversible appliance therapy is a covered benefit, her treatment should be a payable benefit. She says her appliance is a removable device and the treatment is reversible in nature. Once the device is created and fitted, it is altered at least one a month in an office visit (CPT 99214) until stabilization of the internal structures of the TMJ are achieved. The Petitioner believes all this care is covered.

The Petitioner also argues that BCBSM is required to pay the full charge for her care (except for a $10.00 co-payment per treatment) since it denied coverage incorrectly.

BCBSM's Argument

BCBSM agreed to partially reverse an earlier denial and pay, on a one-time exception basis, for some of the Petitioner's claims from XXXXX. The amounts charged by the dentist and the amounts BCBSM agreed to pay are set forth in this table:

Date of Service	Procedure Code	Amount Charged by Provider	BCBSM's Approved Amount	Amount Paid by BCBSM	Co pay	Petitioner's Balance
7-24-07	99244	$ 250.00	$ 218.00	$ 208.00	$10.00	$ 32.00
8-23-07	99245	$ 329.50	$ 276.34	$266.34	$10.00	$ 53.16
9-4-07	99214	$123.50	$102.96	$92.96	$10.00	$20.54
9-18-07	99213	$95.00	$67.95	$57.95	$10.00	$27.05
10-4-07	99214	$123.50	$102.96	$92.96	$10.00	$20.54
10-22-07	99214	$123.50	$102.96	$92.96	$10.00	$20.54
11-6-07	S8262	$1,187.50	$788.27	$709.45	$78.82	$399.23
	Totals	$2,232.50	$1,659.44	$1,520.62	$138.82	$573.06

BCBSM says that the benefit guide, in the section entitled *Physician and Other Professional Services,* explains that BCBSM pays its "approved amount" for physician and other professional services -- the benefit guide does not guarantee that provider charges will be paid in full. However, since Dr. XXXXX does not participate with BCBSM, he is not required to accept BCBSM's approved

amount as payment in full. There is nothing in the certificate that requires BCBSM to pay more than its approved amount, and BCBSM says the Petitioner remains responsible for the balance owed to Dr. XXXXX.

BCBSM also notes that it erroneously applied a flat $10.00 co-payment to most services from XXXXX instead of the 10% co-payment required by the certificate but will let the error stand.

BCBSM also says that while it has agreed to pay for some of XXXXX services, no additional dentist office visits will be covered because payment for the treatment of TMJ problems is limited to services performed by physicians (MD's and DO's, including oral surgeons). Office visits with a dentist (including XXXXX, who is not an oral surgeon) are not a covered benefit.

BCBSM believes that it is not required to pay any additional amount.

Commissioner's Review

There are two issues in the external review. The first is the correct rate of payment for services received from a nonparticipating provider. The benefit guide describes how benefits are paid. It explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the benefit guide (page 80) as "the BCBSM maximum payment level or the provider's billed charge for the covered service, whichever is lower." BCBSM's payment is based on its approved amount to both participating and nonparticipating providers.

According to the benefit guide, participating providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges. The benefit guide (page 17) tells BCBSM members that if a nonparticipating provider is used

> You may also be responsible for any charge above BCBSM's approved amount. That's because providers who don't participate with the Blues may choose not to accept BCBSM's approved amount as payment in full for covered services.

For whatever reason, the Petitioner did not use a participating provider. Nevertheless, BCBSM is correct: there is nothing in the terms and conditions of the Petitioner's coverage that

requires BCBSM to pay more than its approved amount to a nonparticipating provider, regardless of the circumstances.

BCBSM paid for the Petitioner's care by XXXXX based on its full approved amount. It mistakenly applied a $10.00 co-payment (instead of a 10% co-payment) for all but one of the claims but has agreed not to recover the higher payment for these services. For the claims shown in the table above, the Commissioner finds that no further payment is required.

The second issue in this review is whether XXXXX's services are benefits under the Petitioner's coverage. In its final adverse determination, BCBSM said:

> While office visits are covered, payment is limited to those visits/services performed by a physician (MD's and DO's, including oral surgeons). Office visits by a dentist are not covered. Future office visits by a dentist, including XXXX will not be paid.

The benefit guide says that TMJ symptom management services "such as office visits, reversible appliance therapy and physical medicine (diathermy, hot and cold applications) and medications" are covered. BCBSM said that it paid for the office visits with XXXXX on an exception basis because the benefit guide allows payment only for office visits for treatment of TMJ provided by a "physician" (an MD, DO, or oral surgeon) and XXXXX is a DDS, not an oral surgeon. But the benefit guide does not exclude a DDS from providing this care.

BCBSM has not identified its basis for deciding that dentists cannot provide TMJ symptom management services and the Commissioner can find nothing in the benefit guide that excludes them. In fact, the TMJ benefits are in the section of the benefit guide entitled "Physician and Other Professional Services" and "physician" is defined in the benefit guide (page 85) as "a medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS) or doctor of medical dentistry (DMD)." Although the benefit guide contains very limited dental-related benefits, it does not prohibit dentists from providing covered TMJ symptom management services.

No argument was made in this case that the care provided by XXXXX was inappropriate, not

medically necessary, or otherwise excluded. The Commissioner finds that nothing in the benefit guide prohibits TMJ symptom management services from being covered benefits when performed by a licensed dentist as long as the care is shown to be medically necessary and not otherwise excluded. However, in this case, because XXXXX is not a participating provider, the Petitioner remains responsible for the annual deductible, the 10% out-of-network coinsurance, and any difference between the provider charge and BCBSM's approved amount.

V
ORDER

BCBSM's final adverse determination of November 29, 2007, is upheld in part and reversed in part. BCBSM is not required to pay any additional amount for the care provided the Petitioner by Dr. DiStefano from July 24, 2007 through November 6, 2007. BCBSM shall cover the specified TMJ symptom management services from a licensed dentist when medically necessary and subject to any applicable deductibles; co pays, coinsurance, and amounts over and above BCBSM's approved amount, in the case of services received from a non-participating provider.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.